The criteria established by DOH for reviewing child deaths and collecting, tracking and reporting aggregate data differs significantly from that of the Children's Administration.

Due to the many agencies involved in reviewing a child fatality such as coroners and medical examiners, CA does not always receive child fatality data within a specific time frame and annualized data tends to change over time.

Improvements made in 2001 to the Case and Management Information System (CAMIS) have assisted the administration in tracking child fatalities.

The purpose of CA's internal child fatality review process is to conduct a thorough examination of the handling of a case to determine if agency policies, procedures and practices were properly followed. In addition, the review looks generally at policies, procedures and practices to determine if improvements to the Children's Administration system might help to prevent the death of a child in the future.

The administration is striving to better understand how fatalities occur to children who have been referred to or received services from the Children's Administration in an effort to make any needed policy, procedural or practice improvements. The Children's Administration also tracks any reported child fatalities that occur as the result of child abuse or neglect to children who are unknown to the administration or who do not meet the criteria for an internal child fatality review.

Child Deaths Deemed Homicide (Abuse)[4]

Based upon child deaths reported to the Children's Administration; not all child deaths are reported to the administration.

At the time of child's death [1]	1997	1998	1999	2000	2001	2002
Child known to CA and met criteria for CA child fatality review	6	9	4	8	3	7
Child unknown to CA or did not meet criteria for CA review	6	3	4	5	2	7
Total	12	12	8	13	5	14

News Advisory, March 2004
Performance Report, 2003

The Children's Administration has recently developed a new data collection system designed to better track child fatality cases reported to the administration. This new system, called the Administrative Incidents Reporting System (AIRS), incorporates an improved child fatality review tool. AIRS allows the administration to track trends in issues and recommendations made during the internal review process.

1. Data included in the tables presented is based upon reports as of November, 2003 and may change as new reports become available.
2. Third party abuse involves the abuse of a child by someone other than that child's parent or guardian
3. The manner of death was unknown or undetermined by coroners or medical examiners at the time reports were filed with the Children's Administration.
4. Children's Administration divides homicide into two distinct categories; abuse and third party. The table above shows homicide (abuse) indicating that the homicide was found to have been committed by a person in the role of parent or caregiver at the time of the child's death.